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Updated House ACA Repeal Bill Deepens Damaging Medicaid Cuts for Low-Income Individuals and Families

By Edwin Park, Judith Solomon, and Hannah Katch

The updated House Republican plan to repeal the Affordable Care Act (ACA) takes an already damaging plan — the previous version of this House GOP legislation — and makes it even more harmful for the tens of millions of children, seniors, people with disabilities, and other adults who rely on Medicaid.

By effectively ending the Medicaid expansion and converting Medicaid to a per capita cap, the previous version would have cut federal Medicaid spending by \$880 billion over the next ten years and reduced Medicaid enrollment by 14 million people in 2026, the Congressional Budget Office (CBO) estimated.¹ The updated version makes additional changes to Medicaid that are even more damaging overall, including giving states the options to: convert their Medicaid programs into block grants; impose onerous work requirements on adult beneficiaries who are not elderly, disabled, or pregnant; and freeze enrollment in the ACA’s Medicaid expansion starting in 2020. These provisions would likely add to the millions of people who would have Medicaid coverage under the ACA but would become uninsured under this legislation. They also would cut needed care still more deeply for many who keep their Medicaid coverage.

The updated House legislation came yesterday in the form of a “Manager’s Amendment” from House Republican leaders that revises the House GOP legislation to repeal the ACA that the House Budget Committee approved last week. The full House is scheduled to consider the revised bill on Thursday.

Medicaid Block Grant for Children and Adults

As an alternative to the per capita cap, the Manager’s Amendment would give states the option of converting Medicaid to a block grant for children, adults other than seniors and people with disabilities, or both, starting in 2020. This would place three-quarters of Medicaid beneficiaries, including more than 30 million low-income children, at even greater risk of losing their Medicaid

¹ Congressional Budget Office, “American Health Care Act,” March 13, 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf>.

coverage entirely or losing health care services critical for their health and development than under a per capita cap. Both options, however, have the same harmful results: millions would likely end up uninsured or going without needed care as states cut their Medicaid programs to compensate for deep reductions in federal funding.

States adopting the block grant option would be subject to the block grant for at least a ten-year period. The block grant amounts states receive would be based on the product of the per capita amounts the state would have received for children and/or adults if they hadn't chosen the block grant option and actual enrollment in those groups in 2019, increased annually by general inflation. But general inflation would fall well short of expected growth in Medicaid per-beneficiary costs and there wouldn't be any allowance for expected enrollment growth among children and adults as the population grows, so the block grant amounts would become increasingly inadequate over time.

Moreover, a block grant would eliminate Medicaid's ability to respond automatically to increases in need. Instead, states would be fully responsible for bearing all additional costs that result from a recession, as federal Medicaid funding would not increase even as people lost their jobs and health insurance, or when states experienced higher growth in per-beneficiary costs. This means that the magnitude of the federal Medicaid funding cuts that states actually would experience could be considerably larger in any given year than the explicit cuts that would result from the failure of a block grant to keep up with anticipated increases in health care costs.

Nonetheless, the House bill may encourage some states to take up the block grant by reducing the amounts they have to contribute if they use the federal block grant funding and providing them with virtually unfettered flexibility to decide how to spend the federal funds they receive. That's because states could draw down block grant funds at the higher matching rate for the Children's Health Insurance Program, which averages 70 percent, rather the regular Medicaid matching rate (on average, 57 percent). States seeking short-term budgetary savings — and the opportunity to reduce their own contributions to Medicaid in order to finance other budgetary priorities like tax cuts — thus could opt for a block grant. In doing so, they'd deepen the cut in total federal *and* state Medicaid spending in their states, especially over time.

In addition, under the block grant, states would no longer have to comply with most federal Medicaid requirements for children and adults. States could immediately cut eligibility and benefits to avoid any shortfalls and they would be allowed to carry over unused funds to the next year. For example:

- **States would only be subject to minimum income eligibility requirements for children and pregnant women.** This means that states would only have to cover children under age 6 up to 138 percent of the federal poverty line, older children ages 6 to 18 up to 100 percent of the federal poverty line, and pregnant women up to 138 percent of the federal poverty line. States would no longer have to cover parents with incomes at least as high as the income levels at which they covered parents prior to the 1996 welfare reform law, as they do today.
- **States could significantly cut the benefits they offer children and adults.** States would no longer have to cover the comprehensive pediatric benefit that federal law now requires known as EPSDT (Early Periodic Screening, Diagnostic, and Treatment). This critical benefit ensures that low-income children, particularly those with complex health care conditions and other special health care needs, receive screenings and treatment they need. Its loss would be

devastating, especially for children with complex conditions. States would only have to cover a general array of services including hospital care and prescription drugs, although states would be permitted to sharply limit the amount, duration, and scope of these services. This means that children could lose services such as physical and speech therapy and other services that ensure they achieve optimal development.

- **States could also charge unlimited premiums, deductibles, and co-payments.** Under current law, states are generally prohibited from charging premiums related to children’s coverage and can only charge modest co-payments. Substantial research shows that premiums decrease participation of low-income people in coverage and cost-sharing often means they don’t get the health care services they need.²
- **States likely could also deny coverage — through enrollment caps or waiting lists — to anyone who is otherwise eligible, but not required, to be covered under the block grant.** Under current law, states must enroll all eligible individuals.

Over time, states electing the block grant would be forced to use this flexibility to make increasingly draconian cuts to their Medicaid programs, as the block grant funding cuts became increasingly severe. (Moreover, as noted, if states contribute less of their own funding when drawing down the federal block grant funds, resulting in lower overall Medicaid funding, even larger cuts to eligibility, benefits, and provider payments would be necessary.) Notably, these block grant funding cuts would likely lead to deeper cuts to seniors and people with disabilities as well, even though they are not subject to the block grant (but are subject to the per capita cap), as states would have to institute cuts throughout their Medicaid programs.

Medicaid Work Requirement

The Manager’s Amendment would allow states, starting as soon as October 1, 2017, to impose as a condition of eligibility an onerous work requirement on all adults who are not elderly, disabled, or pregnant, something states can’t do under current law. The work requirement could apply to a married mother of a young child, a former foster child attending college, or an individual caring for an aging parent. States would receive a five percentage point increase in the federal match for their administrative costs to implement the work requirement. The work requirement is modeled somewhat on the work requirement in the Temporary Assistance for Needy Families (TANF) program, which has not increased long-term employment among low-income families or reduced poverty but has led to a sharp decrease in the share of low-income families receiving assistance.

Congressional Republican support for a Medicaid work requirement is based on the false premise that large numbers of Medicaid beneficiaries who can work have chosen not to. But the *overwhelming majority* of low-income adults on Medicaid already work. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60 percent are working themselves. Of those

² Judith Solomon, “Indiana Medicaid Waiver Evaluation Shows Why Kentucky’s Medicaid Proposal Shouldn’t Be Approved,” Center on Budget and Policy Priorities, Center on Budget and Policy Priorities, August 2016, <http://www.cbpp.org/blog/replicating-indianas-medicaid-waiver-would-take-kentucky-backward>; and Jessica Schubel and Judith Solomon, “States Can Improve Health Outcomes and Lower Costs in Medicaid Using Existing Flexibility,” Center on Budget and Policy Priorities, April 9, 2015, <http://www.cbpp.org/research/health/states-can-improve-health-outcomes-and-lower-costs-in-medicaid-using-existing>.

not working, more than one-third reported that illness or a disability was the primary reason, 28 percent reported that they were taking care of home or family, and 18 percent were in school.³

Nonetheless, if adopted by states, this provision would likely reduce the number of eligible people who enroll in Medicaid by barring coverage to those who are unable to work or face major barriers to finding and retaining employment. As a result, many would end up uninsured or going without needed care. At the same time, such a work requirement would fail in its stated objective to increase long-term employment, just as similar requirements have failed to increase long-term employment in TANF. In fact, if the resulting loss of coverage led to a deterioration in health for some people, as it well could, a work requirement could make it harder for some of the affected low-income adults to become or remain employed.

- **Medicaid-eligible individuals who don't work now or are not participating in other work activities would be barred from coverage, actually making it less likely they could obtain jobs in the future.** While most adult Medicaid beneficiaries work, the work requirement would provide few exemptions for others. For example, the Manager's Amendment would only exempt sole caretaker parents of young children (under age 6) or of children with disabilities, and those in school if they were under the age of 20. It wouldn't, for example, exempt a young adult attending college, a married mother taking care of an infant, or an adult caring for an aging parent.

Moreover, many of those subject to such a requirement may already have substantial barriers to work that could become worse without access to health coverage — such as opioid addiction or other health conditions that could worsen without treatment. For some of these individuals, access to health services could be the primary pathway to employment; if blocked from Medicaid coverage, they could find it much more difficult to find and hold a job. Ohio's Department of Medicaid found that Medicaid can reduce health barriers to finding or holding a job for beneficiaries who are not working: three-quarters of beneficiaries who received care under the state's Medicaid expansion and who were looking for work reported that Medicaid made it easier to do so. For those who were currently working, more than half said that Medicaid made it easier to keep their jobs.⁴

In addition, there is no requirement for states to provide any resources for job training or other employment services, subsidized jobs, child care assistance, and other work supports to help beneficiaries prepare for work or raise their earnings. Considering that states will experience large and growing cost shifts under the House bill, particularly with the provision to impose a per capita cap or a block grant, it would be highly unlikely that states would have significant new resources to offer necessary work supports. (States currently spend less than 10 percent of their TANF funds on work or work supports such as transportation assistance or work clothes.) As a result, the work requirement would end up being merely punitive for those who already have difficulty finding employment or staying employed.

³ Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, <http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

⁴ Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf>.

- **The TANF experience further demonstrates that a work requirement in Medicaid would do little to increase long-term employment among poor families.** Research shows that employment among TANF cash assistance recipients subject to work requirements rose significantly in the first two years of programs that mandated participation in work-related activities but, by the fifth year, the difference in employment rates between those who faced work requirements and those who didn't had faded. Over five years, at least three-quarters of recipients worked, regardless of whether they faced work requirements. In addition, work requirements made some families worse off.

The share of families living in deep poverty — below half of the poverty line — rose in various TANF programs that imposed work requirements, studies of TANF recipients show. Moreover, before the 1996 welfare law took effect, 68 every 100 poor families with children received basic cash assistance to help make ends meet; today, just 23 do. Sanctions on parents who didn't meet a work requirement have been a factor in that drop.⁵

Work requirements would have other unintended consequences for those unable to work. Although the House health bill exempts people with disabilities, it will be administratively challenging to identify and track people whose disabilities or circumstances ought to exempt them. State TANF programs have failed notably on this front, with studies showing that TANF recipients who are sanctioned for not meeting a work requirement have significantly higher rates of disability than those who are not sanctioned.⁶ People with disabilities, family care responsibilities, or other significant problems or limitations often have difficulty proving they are unable to meet a work requirement.

- **In addition to likely being ineffective in increasing employment over time, a work requirement would add considerable complexity and cost to Medicaid.** State experience in implementing the TANF work requirements suggests that adding similar requirements to Medicaid could cost states thousands of dollars per beneficiary.⁷ States would have to create new programs and hire new staff to track beneficiaries' employment status and cut off their health coverage if they didn't meet the requirements at the same time they are facing cuts in overall federal Medicaid funding. The small increase in federal funding for administrative costs would fall short of covering these added costs.
- **The work requirement would accelerate the end of the Medicaid expansion.** As explained below, the Manager's Amendment and the underlying House bill would effectively end the Medicaid expansion in the 31 states (and the District of Columbia) that have adopted it by substantially cutting the federal matching rate for new expansion enrollees and allowing states to freeze any new enrollment. Because most already enrolled individuals would quickly cycle off the program as their income changes, the expansion would end after several years.

⁵ LaDonna Pavetti, "Work Requirements Don't Cut Poverty, Evidence Shows," Center on Budget and Policy Priorities, updated June 7, 2016, <http://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows>.

⁶ LaDonna Pavetti, Michelle Derr, and Emily Sama Martin, "Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments," Mathematica Policy Research, Inc., February 2008, <https://www.mathematica-mpr.com/our-publications-and-findings/publications/conducting-indepth-assessments>.

⁷ Gayle Hamilton *et al.*, "National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs," Manpower Demonstration Research Corporation, December 2001, Table 13.1.

But if an expansion state took up the work requirement, which it could as early as this year, it would speed up this loss of coverage that would already occur under the House bill, eliminating the expansion even more rapidly.

Freezing Medicaid Expansion Enrollment

The Manager's Amendment changes the bill passed by the Budget Committee to explicitly allow states to freeze enrollment under their Medicaid expansions starting January 1, 2020, and deny coverage to any new enrollees (as well as anyone trying to reenroll after a one-month break in coverage). The Budget Committee bill lowers the 90 percent federal matching rate for new enrollees to the regular matching rate — on average, 57 percent — on January 1, 2020, which would require states to pay 2.8 to 5 times more for expansion enrollees they enroll after that date.

The magnitude of the cost shift would likely lead most or all expansion states to stop enrolling people in their expansions in 2020. But since CBO estimates that more two-thirds of those enrolled as of the end of 2019 will fall off the program by 2021 and fewer than 5 percent of newly eligible enrollees will remain on Medicaid by the end of 2024, the Medicaid expansion would be eliminated after several years except in what will likely be a small number of states that are able and willing to significantly increase their own spending.

Modest Adjustments to Medicaid Per Capita Cap

The Manager's Amendment would raise the growth rate for the per capita cap for both seniors and people with disabilities from the medical care component of the Consumer Price Index (M-CPI) to M-CPI + 1 percentage point. But the higher growth rate would not start until 2020. The base year for computing the per capita caps for seniors and people with disabilities would remain fiscal year 2016, and the growth rate for computing increases in the per capita caps between 2016 and 2019 would remain M-CPI, which means larger cuts from using M-CPI during these years would be permanently incorporated into the per capita cap amounts.

Moreover, while the per capita cap growth rate for seniors and people with disabilities would be higher than the growth rate for children and adults starting in 2020, as federal funding for children and adults becomes increasingly inadequate more rapidly, seniors and people with disabilities would still be subject to the eligibility and benefit cuts resulting from the overall inadequacy of the cap across all groups. That's because under the per capita cap, states receive an overall amount of federal Medicaid funding that is the sum of the products of each population's per capita cap and actual enrollment in that eligibility group. In the face of the overall growing cost shift under the per capita cap, states would have no choice but to cut their entire Medicaid programs to make up for the federal funding shortfalls, regardless of how much each population's per capita cap is contributing to the total shortfall.

In addition, the modestly higher growth rate does not address the long-term effects of aging of the population. As the baby boomers age, a growing share of seniors will move from "young-old age" to "old-old age." People in their 80s or 90s have more serious and chronic health problems and are more likely to require nursing home and other long-term care than younger seniors. For example, seniors aged 85 and older incurred average Medicaid costs in 2011 that were more than 2.5 *times higher* than those aged 65 to 74. This would result in states having to cut their Medicaid programs by increasingly deeper amounts over time.

New York-Specific Provision Related to Per Capita Cap

A provision added to the House Republican bill at the behest of Republican members from upstate New York would effectively force the state of New York to stop requiring that counties contribute to the state's share of its Medicaid costs. (New York City, which now contributes to the cost of Medicaid, would not be affected by this provision.) Under the provision, any required contributions from New York counties would be automatically subtracted from the state's Medicaid per capita cap amount for that year. New York would have to choose whether to take a substantially lower cap amount for that year (relative to what it would have otherwise received), make deep cuts elsewhere in Medicaid to stay within its reduced cap, or as is most likely — and as intended by proponents of the provision — stop requiring counties to contribute towards Medicaid.

The amendment, which is drafted so it applies only to New York and not to other states that require counties or other local governments to contribute a share of Medicaid costs, is clearly designed to get New York to forgo the contributions that counties now make to New York's Medicaid program. New York counties, including New York City, contribute about \$7 billion a year towards the state share for Medicaid. According to press reports, if this provision were in effect this year, New York would have to fill a \$2.3 billion hole in its budget.⁸

This is a transparent attempt by House Republicans to win votes by manipulating the design of the per capita cap to force New York to pick up its counties' share of Medicaid expenditures. The cost shift to the state is on top of the cuts New York would already experience from the loss of enhanced funding for its Medicaid expansion and from the per capita cap itself. New York would have to make even deeper cuts in Medicaid to deal with this added cost shift. This ploy would also likely backfire for the counties, because the amendment's added pressure on the state budget along with the fiscal pressures of the per capita cap itself would likely force the state to make additional budget cuts to other funding to counties and other localities for purposes such as education, roads, and public health. Moreover, to compensate, the state may also simply require counties to contribute other revenues outside of Medicaid to address the resulting budget shortfalls.

⁸ Matthew Hamilton, "Faso backs AHCA amendment to shift county Medicaid costs to states," *Albany Times Union*, March 10, 2017, <http://blog.timesunion.com/capitol/archives/272948/faso-backs-ahca-amendment-to-shift-county-medicaid-costs-to-state/>.